m. Submitting, or causing to be submitted, false information for the purpose of obtaining greater compensation to which the provider is legally entitled (including charges in excess of the fee schedule as prescribed by the Division of Medicaid or usual and customary charges as allowable under the Division of Medicaid regulation).

n. Submitting, or causing to be submitted, false information for the purpose of meeting prior authorization requirements.

o. Exclusion from Medicare because of fraudulent or abusive practices.

p. Conviction of a criminal offense relating to performance of a provider agreement with the State, or for the negligent practice resulting in death or injury to patients.

q. Failure to submit timely and accurately all required resident assessments.

r. Submitting, or causing to be submitted, false information for the purpose of obtaining a greater case mix facility average score in order to increase reimbursement above what is allowed under the plan.

C. Sanctions

After all administrative proceedings have been exhausted, the following sanctions may be invoked against providers based on the grounds specified above:

A. Suspension, reduction, or withholding of payments to a provider,

B. Suspension of participation in the Medicaid Program, and/or

C. Disqualification from participation in the Medicaid Program.

Under no circumstances shall any financial loss caused by the imposition of any of the above sanctions be passed on to recipients, their families or any other third party.

1-8 Public Notification

The Division of Medicaid will provide an opportunity for interested members of the public to review and comment on any significant proposed change in its methods and standards for setting payment rates for services. This will be accomplished by public announcement in the newspaper with widest circulation in each Mississippi city with a population of 50,000 or more. All Nursing

Facilities, Psychiatric Residential Treatment Facilities and ICF-MR's will receive a copy of the public notice. Public notice will be made prior to the proposed effective date of the change. A period of thirty (30) days will be allowed for comment.

1-9 Plan Amendments

Amendments to the Mississippi Medicaid State Plan will be made in accordance with Section 43-13-117 of the Mississippi Code of 1972.

The state has in place a public process which complies with the requirements of Section 1902(a) (13) (A) of the Social Security Act.

Copies of all plan amendments related to Attachment 4.19-D of the Mississippi State Plan will be provided to members of the Technical Advisory Committee on Case Mix Reimbursement and Quality Assurance.

1-10 Technical Advisory Committee on Case Mix Reimbursement and Quality Assurance

A Technical Advisory Committee on Case Mix Reimbursement and Quality Assurance shall be appointed by the Executive Director of the Division of Medicaid to serve in an advisory capacity. The State Medicaid staff shall utilize the committee for advice in sharing their specialized knowledge in geriatrics; resident care in long-term, institutional facilities; nursing facility operations and financing; and quality care standards and measurements.

1-11 Special Services

A. Swing Bed Services

Reimbursement. Swing-bed providers will be reimbursed for the eligible days of care rendered Medicaid recipients in each calendar month. The rates will be redetermined annually for the reimbursement period July 1 through June 30. The methods and standards for determining the

reimbursement rate for swing-bed services will be the statewide average rate paid under the State Plan during the previous calendar year to Nursing Facilities.

The swing-bed provider will be responsible for collecting that portion of the total amount (days X rate) owed by the Medicaid recipient as indicated on the Division of Medicaid Form DOM-317. Hospitals operated in conjunction with a distinct part nursing facility will not receive swing-bed reimbursement for those patient days when empty distinct part long-term care beds are available. Hospitals may bill for those ancillary services rendered to swing-bed patients and not customarily furnished by nursing facilities such as a hospital outpatient claim or lab referral claim.

Cost Reporting. Swing-bed providers will not file separate cost reports required of other nursing facilities, nor will rates or amounts paid for swing-bed care be considered in the determination of nursing facility rates. In order to allocate

costs between hospital and swing-bed services in the participating provider's hospital cost report, the total reimbursement due for swing-bed patients will be subtracted from the hospital's total costs before determining allowable costs for routine hospital services under the State Plan.

B. Services for Children Under Age 21

Any services required for children under age 21, that are not covered elsewhere in this plan, will be provided.

Reimbursement for these services will be at an amount not greater than ninety percent (90%) of the provider's usual and customary charges for the services.

Services that are required for children under age 21 that are available only in a state other than Mississippi will be reimbursed at the lower of the provider's Medicaid rate, as defined by the Medicaid agency in the provider's state of operation, or the Mississippi Medicaid maximum rate for that classification of facility. If the services are required at a type of facility for which the Mississippi Medicaid plan does not provide payment methodology, reimbursement will be made at the lesser of the provider's Medicaid rate, as defined by the Medicaid agency in the provider's state of operation or an amount not greater than ninety percent (90%) of the provider's usual and customary charges for the services. The Division of Medicaid will not reimburse a facility at a rate greater than the provider's customary charges to the general public for the services.

CHAPTER 2

STANDARDS FOR ALLOWABLE COSTS

2-1 Allowable and Non-Allowable Costs

The Division of Medicaid defines allowable and non-allowable costs to identify expenses which are reasonable and necessary to provide care to Nursing Facility, PRTF and ICF-MR residents. The standards listed below are established to provide guidance in determining whether certain selected cost items will be recognized as allowable costs. In the absence of specific instructions or guidelines in this manual, facilities will submit cost data for consideration for reimbursement. Allowable costs must be compiled on the basis of generally accepted accounting principles (GAAP). In cases where Division of Medicaid cost reporting rules conflict with GAAP, IRS or HIM-15, Division of Medicaid rules take precedence for Medicaid provider cost reporting purposes. Allowable costs are based on HIM-15 standards except as otherwise described in this manual. If the Division of Medicaid classifies a particular type of expense as non-allowable for the purpose of determining the rates, it does not mean that individual providers may not make expenditures of this type.

A. Allowable Costs

In order for a cost to be an allowable cost for Medicaid reimbursement purposes, it must be reasonable and necessary in the normal conduct of operations related to providing patient care in accordance with HIM-15 guidelines.

The following list of allowable costs is not comprehensive, but serves a general guide and clarifies certain key expense areas. The absence of a particular cost does not necessarily mean that it is not an allowable cost.

1. Accounting Fees. Accounting fees incurred for the preparation of the cost report, audits of the financial records, bookkeeping services, tax return preparation of the nursing facility and other related services are allowable costs. Accounting fees incurred for personal tax planning and income tax preparation of the owner are not allowable costs.

2. Advertising Costs - Allowable. The allowability of advertising costs depends on whether they are appropriate and helpful in developing, maintaining, and furnishing

covered services to Medicaid beneficiaries by providers of services. In determining the allowability of these costs, the facts and circumstances of each provider situation as well as the amounts which would ordinarily be paid for comparable services by comparable institutions will be considered. To be allowable, such costs must be common and accepted occurrences in the field of the provider's activity.

Advertising costs incurred in connection with the provider's public relations activities are allowable if the advertising is primarily concerned with the presentation of a good public image and directly or indirectly related to patient care. Examples are: visiting hours information, conduct of management-employee relations, etc. Costs connected with fund-raising are not included in this category.

Costs of advertising for the purpose of recruiting medical, paramedical, administrative and clerical personnel are allowable if the personnel would be involved in patient care activities or in the development and maintenance of the facility.